Great-West®
HEALTHCARE

Flexible Spending Account (FSA) Enrollment Form

Directions to complete FSA enrollment form:

A. Please print and complete all participant information under section **A**, including your company name and plan number

B. Complete the election information under section **B**

Note: Total annual elections are divided by the number of payroll occurrences during the remainder of the plan year

i. **Health Flexible Spending Account-** Reimbursement account to pay for eligible expenses not covered by your health plan for you, your spouse and any dependents

ii. **Dependent Care Flexible Spending Account-** Reimbursement account to pay for dependent child care expenses, such as daycare

C. Sign and date the form in section **C** and return to your employer

Employer Use Only:

1. **Number of FSA salary deferral deductions** _____
2. **Employee Payroll frequency (please select one)**
   Monthly ☐ Bi-weekly ☐
   Semi-monthly ☐ Weekly ☐
3. **FSA Election Effective Date**_____/_____/_____
4. **Date of first FSA salary deferral deduction**_____
5. **Division Number (if applicable)**_____

A

Employee Name: _____ SSN/ID#: _____

Employee Address: _____
(city) (state) (zip code)

Employee Phone Number: _____ Date of birth (mm/dd/yy): ____/_____/_____

Company Name: _____ Group Plan Number:_____

IMPORTANT NOTE: If you or your spouse have opened, or plan to open, an HSA, you may *not* elect a Health Flexible Spending Account. This does not apply to the Dependent Care Flexible Spending Account.

B

HEALTH FLEXIBLE SPENDING ACCOUNT

Total Annual Employee Election $_____ (Maximum is determined by your Employer)

Automatic Claim Submission **I choose to elect Automatic Claim Submission (if offered under my Employer's Plan)** ☐ **Yes** ☐ **No**

By signing below, I hereby certify that (1) I have read and understand the Automatic Claim Submission (ACS) terms and conditions as explained on Page 2 of this form; (2) I hereby authorize Great-West Healthcare to reimburse me through my Health Flexible Spending Account for all allowable charges on claims which are considered, but not fully paid, by my Employer's health plan offered through Great-West Healthcare; (3) I understand and agree that all of my Health FSA claims processed under the ACS feature are considered to be submitted to the Health FSA plan on the date a final claim decision under my employer's health plan is forwarded to the Health FSA plan's claims administrator; (4) the ACS process will stop once my Health FSA benefit balance has been exhausted; (5) I meet the eligibility requirements set forth on page 2 of this form; and (6) with respect to all my Health FSA claims processed under the ACS feature, I certify that: I (and/or my spouse and/or dependent) have incurred the expenses for reimbursement from my health FSA; these expenses were not reimbursed, and are not reimbursable by any other benefit plan; and I (we) will not claim the expenses reimbursed through my Health FSA as deductions or credits when filing my (our) individual tax return. I agree to refund the plan for any Health FSA reimbursement I receive that fails to meet any of the conditions stated in (5) and (6).

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Total Annual Employee Election $_____ (Maximum $5,000 if filing jointly, filing separately, $2,500 maximum)

C

I hereby authorize my election(s) and pre-tax salary contribution(s) for the account(s) designated above for the plan year. I understand that this election is an annual election and cannot be changed during the plan year except in the case of a qualified change in family status. I understand that any unused balances in either account at the end of the plan year, including the incurred claims grace period if applicable, shall be forfeited. If I have elected Automatic Claim Submission, I certify that I meet the eligibility requirements set forth on Page 2. Further, I understand that I must *revoke* such election if at any time during the plan year if I fail to meet the eligibility requirements.

Employee Signature: _____ _____ **Date:** _____/_____/_____

Great-West Healthcare refers to products and services provided by Great-West Life & Annuity Insurance Company and its subsidiaries (Alta Health & Life Insurance Company and Great-West Healthcare HMO/HCSC companies). It also refers to New England Life Insurance Company's and Metropolitan Life Insurance Company's group business currently administered by Great-West. Great-West Life & Annuity Insurance Company is not licensed to do business in New York. Products are sold in New York by its subsidiary First Great-West Life & Annuity Insurance Company, White Plains, N.Y.

FSA Worksheet

Your Eligible Expenses

1. Eligible Health Flexible Spending Account Expenses

- Deductibles, Co-payments $ _____

- Out-of-pocket costs for eligible expenses that will not be covered under any health plan or are subject to coinsurance cost sharing:
  - Hospital expenses _____
  - Physician expenses _____
  - Dental expenses _____
  - Vision and eye care, i.e., exams, glasses, contacts, radial keratotomies _____
  - Hearing expenses, i.e., exams, hearing aids _____
  - Physical examinations, i.e., annual checkups, school exams _____
  - Psychiatric counseling _____
  - Chiropractic and acupuncture treatment _____
  - Prescription drugs, insulin, contraceptives _____
  - Drug or alcohol treatment _____
  - *Other* health care-related expenses _____
- Eligible over-the-counter medications _____

Total Estimated Eligible Health Flexible Spending Account Expenses $ _____

2. Eligible Dependent Care Flexible Spending Account Expenses

Estimate the total amount you pay during the year for daycare provided for your child or elderly or disabled family member. Then enter how much of that amount you want to redirect in the Dependent Care Flexible Spending Account.

Total Estimated Dependent Care Flexible Spending Account Expenses $ _____

Based on your elections (on Page 1) and subject to the Plan's rules and maximum benefits provisions, your payroll administrator will calculate your pre-tax deduction per paycheck for Health Flexible Spending Account and Dependent Care Flexible Spending Account expenses.

Eligible expenses are determined by the applicable provisions of the plan, based on IRS guidelines for FSA programs under Sections 105, 125 and 129 of the Internal Revenue Code.

An electronic version of this calculator is also available on the web at www.mygreatwest.com .

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